
APPLICATION FOR UNITED STATES LETTERS PATENT

for

**MINIMALLY INVASIVE METHOD FOR IMPLANTING A
SACRAL STIMULATION LEAD**

by

**George Mamo
and
Michele Spinelli**

ATTORNEY OF RECORD:

ERIC R. WALDKOETTER
Attorney Registration No. 36,713
MEDTRONIC, INC.
7000 Central Avenue N.E
Minneapolis, Minnesota 55432
Telephone: (763) 514-3201
Facsimile: (763) 514-3233

CERTIFICATE OF EXPRESS MAIL

Mailing Label No. EL 084633248 US
Date of Deposit: NOVEMBER 15, 2000

I hereby certify that this paper or fee is being deposited with the United States Postal Service as "'EXPRESS MAIL' POST OFFICE TO ADDRESSEE" service under 37 CFR 1.10 on the date indicated above and is addressed to the Commissioner of Patents and Trademarks, Washington D.C. 20231

JUANITA I. TRAUFLER
Printed Name

Juanita I. Traufler
Signature

MINIMALLY INVASIVE METHOD FOR IMPLANTING A SACRAL STIMULATION

LEAD

CROSS REFERENCE

5 This disclosure is related to the following copending application entitled "Minimally Invasive Surgical Techniques For Implanting Devices That Deliver Stimulation To The Nervous System" by inventors Gerber et al. (Application No. 09/489,544; filed January 31, 2000), which is not admitted as prior art with respect to the present disclosure by its mention in this cross reference section.

BACKGROUND OF THE INVENTION

10 This disclosure relates to a method for surgically implanting an electric neurostimulation lead in the human sacrum.

15 The medical device industry produces a wide variety of electronic and mechanical devices for treating patient medical conditions. Depending upon the medical condition, medical devices can be surgically implanted or connected externally to a patient receiving treatment. Clinicians use medical devices alone or in combination with drug therapies and surgery to treat patient medical conditions. For some medical conditions, medical devices provide the best, and sometimes the only, therapy to restore an individual to a more healthful condition and a fuller life. Conditions that medical devices can effectively treat include pelvic floor disorders.

20 Pelvic floor disorders adversely affect the health and quality of life of millions of people. Pelvic floor disorders include urinary control disorders such as urge incontinency, urge frequency, voiding efficiency, fecal control disorders, sexual dysfunction, and pelvic pain. Individuals with urinary control disorders often face debilitating challenges in their everyday

lives. These individuals can be preoccupied with trips to the bathroom, fears of embarrassment, and sleepless nights. Some suffers become so anxious that they become isolated and depressed. Pelvic floor disorders can be treated with a variety of therapeutic options such as behavior modification including biofeedback, pharmacological treatment, mechanical intervention such as self-catheterization, physical appliances such as diapers, and surgical intervention. Surgical treatments are the most invasive and are often considered after other therapies have proven ineffective.

One surgical technique to treat urinary control disorders is the implantable InterStim® therapy, available from Medtronic, Inc., which applies mild electrical stimulation to the sacral nerves in the lower region of the spine to influence behavior of structures such as the bladder, sphincter and pelvic floor muscles. Generally, implantation of InterStim therapy involves surgically implanting a stimulation lead near the sacral nerves. The stimulation lead is a very small, insulated electrical conductor with electrical stimulation contacts on the distal end placed near the sacral nerves and an electrical connector on the opposite proximal end of the lead. The lead electrical connector is typically connected to a small extension, and the extension is connected to a small neurostimulator that operates similar to a cardiac pacemaker by delivering occasional small electrical pulses that sometimes create a tingling sensation felt by the patient. The stimulation lead, lead extension, and neurostimulator are all implanted in the patient in a manner that is typically not perceptible by others. InterStim therapy can improve the condition of a pelvic floor disorder patient and allow the patient to lead a full life. Also, InterStim therapy is nondestructive and reversible.

Previous surgical methods to implant a neurostimulation lead in a patient's sacrum to treat pelvic floor disorders have been invasive by requiring a large sacral incision in a procedure

known as dissection. FIG. 1a (prior art) shows a sacral dissection. Dissection involves making a
midline incision over the sacrum from a little below S4 up to S1 that in an adult ranges from
about 7.62 cm (3.0 inches) to 12.7 cm (5.0 inches). After the incision is made, the fascia lateral
to the midline is cleaned off and divided in the direction of the incision approximately one finger
5 width lateral to the midline. Next, the paraspinal muscle fibers are split and sharply retracted.
Once the muscle fibers are retracted, the sacral foramen is exposed while preserving the
periosteum. Next, the desired foramen is located by observing anatomical landmarks and
palpating for a marble-board-like depression. FIG. 1b (prior art) shows a foramen dissection.
Once the desired foramen is located, another small incision is made over the desired foramen that
10 is large enough to allow insertion of the stimulation lead. The stimulation lead is inserted
through the incision. Surgically implanting the stimulation lead in this manner near the patient's
sacral nerve can cause patient complications, create significant patient's recovery time, and
create a significant expense to the healthcare system. An example of the previous surgical
method to implant a neurostimulation lead is described in Medtronic, "InterStim® Therapy
15 Sacral Nerve Stimulation For Urinary Control Therapy Reference Guide," Section 5 InterStim
Device Implantation Procedure, pp. 51-52 (1999).

For the foregoing reasons, there is a need for a less invasive surgical method to implant a
neurostimulation lead in a patient sacrum's to reduce patient surgical complications, reduce
patient recovery time, and decrease surgical costs while maintaining the substantial patient
20 benefit that implanting a stimulation lead for sacral neurostimulation can provide.

SUMMARY OF THE INVENTION

The minimally invasive method for sacral stimulation lead implantation in a patient
begins by inserting a needle posterior to the sacrum through an entry point. The needle is guided

into a foramen along an insertion path to a desired location. The insertion path is dilated with a dilator to a diameter sufficient for inserting a stimulation lead. The needle is removed from the insertion path. The stimulation lead is inserted in the insertion path to the desired location.

Finally, the dilator is removed from the insertion path. Additionally if the clinician desires to

separately anchor the stimulation lead, an incision can be created through the entry point from an epidermis to a fascia layer. The stimulation lead is anchored to the fascia layer. Finally, the incision is closed. The minimally invasive method for sacral stimulation lead implantation can be practiced in a wide variety of embodiments.

BRIEF DESCRIPTION OF THE DRAWINGS

FIG. 1a shows a prior art sacral dissection;

FIG. 1b shows a prior art foramen dissection;

FIG. 1c shows an environment of a patient undergoing a sacral stimulation procedure;

FIG. 2 shows an embodiment of an implanted neurostimulator;

FIGS. 3a-3g show some surgical tools that can be used to perform the minimally invasive method;

FIG. 4 shows a flowchart of a first minimally invasive method embodiment;

FIG. 5a shows a flowchart of a second minimally invasive method embodiment;

FIG. 5b shows a needle being inserted into a foramen embodiment;

FIG. 5c shows a cross section view of FIG. 5b;

FIG. 5d shows the needle being used as a guide for a larger needle embodiment;

FIG. 5e shows removal of a stylet and insertion of a stimulation lead embodiment;

FIG. 5f shows another view of insertion of the stimulation lead embodiment;

FIG. 5g shows removal of the needle and insertion of an anchor embodiment;

FIG. 5h shows fixation of the anchor embodiment;

FIG. 5i shows another stimulation lead fixation embodiment;

FIG. 5j shows another view of the stimulation lead fixation embodiment shown in the FIG. 5i embodiment;

5 FIG. 5k shows an anchored stimulation lead that is tunneled for connection to a medical device;

FIG. 6a shows a flowchart of a third minimally invasive method embodiment;

FIG. 6b shows a patient having a needle inserted posterior to the patient sacrum embodiment;

FIG. 6c shows an anatomical drawing of the needle inserted as shown in the FIG. 6b embodiment;

10 FIG. 6d shows a patient having a guide wire inserted through the needle;

FIG. 6e shows an anatomical drawing of the guide wire inserted as shown in the FIG. 6d embodiment;

FIG. 6f shows a patient having a dilator placed over the guide wire embodiment;

FIG. 6g shows an anatomical drawing of the dilator placed over the guide wire as shown in the FIG. 6f embodiment;

FIG. 6h shows a patient having the dilator inserted into the sacrum embodiment;

FIG. 6i shows an anatomical drawing of the dilator inserted into the sacrum as shown in the FIG. 6h embodiment;

FIG. 6j shows preparation for inserting the stimulation lead into the dilator embodiment;

20 FIG. 6k shows inserting the stimulation lead into the dilator embodiment;

FIG. 6l shows removal of the dilator embodiment;

FIG. 6m shows creating an incision at the stimulation lead insertion site embodiment;

FIG. 6n shows marking the stimulation lead embodiment;

FIG. 6o shows an anatomical cross-section drawing of marking the stimulation lead embodiment;

FIG. 6p shows applying a lead anchor to the stimulation lead embodiment;

FIG. 6q shows tunneling the stimulation lead embodiment;

FIG. 6r shows fixation of the lead anchor to the lead body embodiment;

5 FIG. 6s shows fixation of the lead anchor to fascia of the patient embodiment;

FIG. 7a shows a flowchart of a fourth minimally invasive embodiment;

FIG. 7b shows an anatomical cross-section of creating an incision and inserting the needle
embodiment;

FIG. 7c shows an anatomical cross-section of insertion of the guide embodiment;

10 FIG. 7d shows an anatomical cross-section of the guide in place after the needle has been
removed embodiment;

FIG. 7e shows an anatomical cross-section of placement of the stimulation lead over the guide
embodiment;

FIG. 7f shows an anatomical cross-section of fixing the stimulation lead to a patient's fascia and
15 removal of the guide embodiment; and,

FIG. 7g shows an anatomical cross-section of closing the incision and tunneling the stimulation
lead embodiment.

DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENTS

FIG. 1c shows an environmental view of a sterile area in which the minimally invasive
20 method for implanting a sacral stimulation lead can be performed. The method can be performed
in a wide variety of locations 20 that have a sterile field and common medical instruments such
as an operating room, surgery center. The method and its many embodiments are typically
performed by a urologist 22, but can be performed by many clinicians 22 trained in stimulation

lead implantation. The patient 24 is placed under local or general anesthesia. With local anesthesia, the method can potentially be performed in a clinician's 22 office for greater accessibility and reduced costs. A sacral stimulation lead can be implanted for a variety a purposes such as to treat pelvic floor disorders. Pelvic floor disorders include urinary control disorders, fecal control disorders, sexual dysfunction, and pelvic pain.

FIG. 2 shows an embodiment of an implanted neurostimulator 26 to stimulate sacral nerves 27 located near the sacrum 28. The sacral nerves are assessable through an entry point 29 along an insertion path 33 into a foramen 31 to reach a desired location 35. A neurostimulation system can include a stimulation lead 30, a lead anchor (FIG. 3g), a lead extension 32, a trial stimulator (not shown), an implantable neurostimulator 26, a physician programmer (not shown), and a patient programmer (not shown). The stimulation lead 30 has electrical contacts 34 positioned on the distal end to stimulate nerves and connectors (not shown) on the proximal end to connect to a lead extension or directly to the trial neurostimulator or implantable neurostimulator 26. The stimulation lead 30 can be a Medtronic Model 3886 quadrapolar lead without anchor having a diameter of approximately a 0.127 cm (0.050 inch) and designed to accept a stylet through the center of the stimulation lead 30 to assist in insertion. The lead anchor (FIG. 3f) fixes the stimulation lead 30 to prevent the stimulation lead 30 from migrating away from the position selected by the implanting clinician 22. The lead extension 32 connects between the stimulation lead 30 and the trial stimulator or implantable stimulator 26. The trial neurostimulator tests the effectiveness of stimulation to treat the patient's condition prior to implantation of an implantable neurostimulator 26.

The implantable neurostimulator 26 provides a programmable stimulation signal that is delivered to a desired location or target to stimulate selected nerves. The implantable

neurostimulator 26 is typically implanted in a subcutaneous pocket around the upper buttocks sometime after the stimulation lead 30 has been implanted and its effectiveness verified. The physician programmer is used by the clinician 22 to communicate with the implantable neurostimulator 26 to program the stimulation signal produced by the implantable

5 neurostimulator. The patient programmer allows the patient to communicate with the implantable neurostimulator to control certain parameters of the stimulation signal typically selected by a clinician. With a pelvic floor disorder, a patient can typically control stimulation signal parameters such as voltage amplitude. Neurostimulation systems with the components discussed above are available from Medtronic, Inc. in Minneapolis, Minnesota.

10 FIGS. 3a-3g show some of the surgical instruments (not to scale) typically available to the implanting clinician to aid in implanting the stimulation lead 30. Local anesthetic is delivered to the patient typically with a syringe such as a Luer Slip Disposable 12cc syringe (not shown). The needle 36 is selected based upon the needs of the patient 24 typically ranging in size from an outer diameter of about 26 gauge to about 12 gauge such as the 20 gauge, thin wall, 15 foramen needle 38 Models 041828 and 041829 available from Medtronic. The foramen needle 38 has a stylet 40, also known as an obturator, in the foramen needle 38 central opening and markings that measure 1.0 cm increments and a wider mark at 5.0 cm to aid in positioning needle depth. Additionally the foramen needle 38 tip and proximal portion adjacent to the hub are conductive, so a trial stimulator can be electrically connected to the hub. The trial stimulator 20 stimulation signal will travel to the foramen needle 38 tip to evoke a response from the patient 24 to determine if the foremen needle 38 is properly position and whether the patient 24 will likely benefit from stimulation.

The dilators 42 can be metal or plastic dilators typically ranging in size from an outer diameter of about 5 French to about 14 French, such as an Angiocath® intravenous catheter placement unit available from Parke Davis & Company, selected based upon the size of stimulation lead 30 to be implanted. Multiple dilators 42 can be used typically in sequence from a smaller diameter to a larger diameter to achieve the desired dilation while controlling tissue trauma. The guide wire 44 is typically a thin biocompatible stainless steel wire with a diameter such as 0.076 cm (0.030 inch). Dilators 42 and guide wires 44 are available in cardiac pacing lead introducer kits such as Medtronic's Model 3208, Percutaneous Lead Introducer. The dilator 42 can be a metal or plastic dilator sized appropriately to pass the stimulation lead 30 such as an 8 French sized dilator. The neurostimulation lead anchor 46 is an implantable surgical anchor configured to fix to the stimulation lead 30 such as a suture anchor or a twist-lock anchor available in the Medtronic Model 3550-1 Boots and Anchors Accessory Kit or the silicone anchor included in the Medtronic Model 3886 Lead Electrode Kit. Additionally to assist the clinician 22 in guiding placement of the needle 36 and guide wire 44, the clinician 22 may use a fluoroscope or x-ray machine.

First Minimally Invasive Method Embodiment

FIG. 4 shows a flowchart of a first embodiment of the minimally invasive implantation method. FIG. 2 shows an embodiment of an implanted neurostimulator 26 to stimulate sacral nerves 27, and FIGS. 3a-3g show some surgical tools that can be used to perform the minimally invasive method. Prior to beginning the first method for minimally invasive method embodiment 48 for sacral electrical stimulation lead 30 implantation in a patient 24, the following preparatory actions are typically taken. A local anesthetic is typically applied to anesthetize the area where the stimulation lead 30 will be implanted such as posterior to the

sacrum 28. Since embodiments of the method permit use of a local anesthetic, patients 24 can be treated on an outpatient basis to greatly reduces costs over inpatient care and reduce recovery time. This significant cost reduction also makes sacral stimulation lead 30 implantation and its many beneficial therapies available to more patients 24 because healthcare payers are more likely to cover procedure costs. Also by using local anesthesia, the implanting clinician 22 can use the patient's 24 conscious sensory response to stimuli such as trial stimulation to aid in placing the stimulation lead 30. By using the patient's 24 conscious sensory response during stimulation lead 30 placement, the stimulation lead 30 can be more accurately placed reducing the potential for an ineffective therapy and reducing the potential for patient 24 injury caused by a misplaced lead 30. Other forms of anesthesia can also be used such as general anesthesia. Once the patient 24 has been anesthetized, the first method embodiment 48 can begin.

A needle 36 is inserted 50 posterior to the sacrum 28 through an entry point 29 typically created with the needle 36. The needle 36 can take a variety of forms such as a needle without a hub (cannula), a solid rod with a sharp tip, a needle with a hub that can be removed for example by a cutting tool, or a foramen needle 38 modified to have an extended length and a hub that can be removed with a cutting tool. The entry point 29 is typically a percutaneous entry created when the needle 36 is inserted. The needle 36 is hand guided 52 into the foramen 31 along an insertion path 33 to a desired location 35. The foramen's 31 approximate location can be found using anatomical landmarks, fluoroscopy, or x-rays. When guiding 52 the needle 36, the position of the needle 36 can be sensed by a variety of means such as by applying an electrical signal to the needle 36 to evoke a patient 24 response such as a motor or sensory response. Once the needle 36 is in position, the needle 36 can remain in the position to serve as a guide for the dilator 42, or in the alternative a guide wire 44 can be inserted through the needle 36. When the

needle 36 is used as a guide for the dilator 42, the needle hub 45 typically must be removed before the dilator 42 can be guided over the needle 36. Alternatively, a guide wire 44 can be used as the guide for the dilator 42. The guide wire 44 can be a flexible guide wire, a stiff guide wire, or a stylet. Once the guide wire 44 is in position, the needle 36 can be removed, and the
5 guide wire 44 can serve as a guide for the dilator 42.

The insertion path 33 is dilated 54 with a dilator 42 to a diameter sufficient for inserting a stimulation lead 30. The needle 36 is removed 56 from the insertion path 33, or alternatively the guide wire 44 is removed 56 from the insertion path 33. When removing 56 the needle 36 from the insertion path 33, care should be taken to avoid displacing the dilator 42. The stimulation
10 lead 30 is inserted 58 to the desired location 35. Since the chronic stimulation lead 30 is being inserted 58 directly without the requirement for a separate test stimulation lead (not shown), such as a Medtronic Test Simulation Lead Model 3057, the chronic stimulation lead 30 can be placed without positioning repeatability variation. Also, there is a greater correlation between acute test stimulation and chronic therapy stimulation because the same lead 30 is performing both test
15 stimulation and therapy stimulation. The desired location 35 can be any area of the sacrum 28 intended to achieve a therapeutic effect such as into the foremen 31. One way to verify the stimulation lead's 30 position is to apply an electrical signal to the stimulation lead 30 to evoke a patient 24 motor or sensory response. Other ways to verify the stimulation lead's 30 position include imaging techniques such as fluoroscopy and x-ray. When inserting 58 the implantable
20 stimulation lead 30, the lead 30 is advanced through the dilator 42 to the desired location 35 for stimulation. The dilator 42 is removed 60 from the insertion path 33. When removing 60 the dilator 42 from the insertion path 33, care should be taken to avoid displacing the stimulation lead 30. Additionally, stimulation lead 30 position should be re-verified by one of the previously

discussed techniques. Once the dilator 42 is removed, the clinician 22 may decide that the lead 30 does not need to be fixed because the patient's 24 physiology itself adequately stabilizes the lead 30. When the stimulation lead 30 is not separately fixed, patient 24 tissue disruption is minimized which provides for faster patient 24 recovery and potentially less stimulation lead 30 migration caused by disrupted tissue changes. If the clinician 22 does not wish to separately fix the stimulation lead 30, the first method embodiment 48 is completed. Optionally, the clinician 22 can separately fix the stimulation lead 30 by creating an incision 62, anchoring the lead 64, and closing the incision 66.

FIG. 5h shows an embodiment for separately fixing the stimulation lead. To separately fix the stimulation lead 30, an incision 68 through the entry point 29 is created from an epidermis 70 to a fascia layer 72 such as the lumbosacral fascia layer. This incision 68 can also be created at a later point in the method embodiment 48 without adversely affecting the method. The stimulation lead 30 is anchored 64 to the fascia layer 72. When anchoring 64 the stimulation lead 64 care is again should be taken to avoid displacing the stimulation lead 30. Finally, the incision 68 created for the anchor is closed 66. Since the first method embodiment 48 disrupts less tissue than the prior art method, patient 24 tissue disruption is minimized which provides for faster patient recovery and potentially less stimulation lead 30 migration caused by disrupted tissue changes.

A portion of the first minimally invasive method embodiment 48 can also be used simply for stimulation lead 30 placement for acute test stimulation rather than implantation. For stimulation lead 30 placement, typically the same procedure is used as for implantation through removing the dilator 60 from the insertion path 33. Once the dilator 42 is removed, stimulation lead 30 placement is validated to ensure the stimulation lead 30 is in the desired location 35.

Second Minimally Invasive Method Embodiment

FIG. 5a shows a flowchart of a second minimally invasive implantation method embodiment 74, and FIGS 5b-5k show various implementation element embodiments. The second minimally invasive method embodiment 74 is similar to the first minimally invasive method embodiment 48 with the exception that in the second method embodiment 74 includes an incision for anchoring that is created 62 after the needle has been guided 52 to a desired location 35 that is optional in the first method embodiment 48. By making the incision 62 earlier than optionally performed in the first minimally invasive method 48, the stimulation lead 30 can be more easily anchored 64 to a fascial layer 72 such as the lumbosacral fascia layer closer to the stimulation lead 30 distal end.

A portion of the second minimally invasive method embodiment 74 can also be used simply for stimulation lead 30 placement for acute test stimulation rather than implantation. For stimulation lead 30 placement, typically the same procedure is used as for implantation through removing the dilator 60 from the insertion path 33. Once the dilator is removed 60, stimulation lead 30 placement is validated to ensure the stimulation lead 30 is in the desired location 35.

Third Minimally Invasive Method Embodiment

FIG. 6a shows a flowchart of a third minimally invasive implantation method embodiment 76, and FIGS. 6b-6o show various implementation element embodiments. The third minimally invasive method embodiment 76 is similar to the first minimally invasive method embodiment 48 with the exception that a guide wire 44, stylet, or long needle is inserted 78 to guide the dilator 42 and the guide wire 44 is removed 80 after dilation has been completed. More specifically, after the needle 36 has been guided 52 into the foramen along an insertion path 33 to a desired location 35, a guide wire 44 is inserted into the needle 36 to the desired

location 35. Once the guide wire 44 is in place, the needle 36 is removed 56 while retaining the guide wire 44 at the desired location 35. The dilator 42 is placed over the guide wire 44 along the insertion path 33 to dilate 54 the insertion path 33 to a diameter sufficient for inserting 58 a stimulation lead 30. Once the dilator 42 is in place, the guide wire 44 is removed 80 from the dilator 42. After the stimulation lead 30 is in the desired location 35, the dilator 42 is removed 60. With the third minimally invasive method 76, once the dilator 42 is removed 60, the additional steps of creating an incision 62, anchoring the lead 64, and closing the incision 66 are optional. Once the dilator 42 is removed 60, the clinician 22 may decide that the stimulation lead 30 does not need to be fixed because the patient's 24 physiology itself adequately stabilizes the stimulation lead 30. If the clinician 22 determines the patient 24 requires the stimulation lead 30 fixation, then the clinician 22 would perform the elements of creating an incision 62, anchoring the lead 64, and closing the incision 66 as discussed previously.

A portion of the third minimally invasive method embodiment 76 can also be used simply for stimulation lead 30 placement for acute test stimulation rather than implantation. For stimulation lead 30 placement, typically the same procedure is used as for implantation through removing 60 the dilator 42 from the insertion path. Once the dilator 42 is removed 60, stimulation lead 30 placement is validated to ensure the stimulation lead 30 is in the desired location 35.

Fourth Minimally Invasive Method Embodiment

FIG. 7a shows a flowchart of a fourth minimally invasive implantation method embodiment 82, and FIGS. 7b-7g show various implementation element embodiments. The fourth minimally invasive method embodiment 82 is similar to the second minimally invasive method embodiment 74 with the exception that a guide wire 44 or stylet is inserted 78 to guide

the stimulation lead 30 and the stimulation lead 30 functions as the dilator 42, so a separate dilator 42 is not used. More specifically, after the incision 68 is created 62, a guide wire 44 is inserted 78 into the needle. Once the guide wire 44 is in the desired location 35, the needle 36 is removed 56 from the insertion path 33. In one embodiment, the stimulation lead 30 is configured with a centrally located stylet lumen and a pointed tip, so the stimulation lead 30 can serve as the dilator 42. The stimulation lead 30 is inserted over the guide wire 44 to the desired location 35. In another embodiment, the stimulation lead 30 is configured with a stylet lumen and also a pointed tip, so the stimulation lead 30 can serve as the dilator 42. The stimulation lead 30 stylet lumen is inserted 58 over the guide wire 44 and the stimulation lead 30 is advanced to the desired location 35. After the stimulation lead 30 is in the desired location 35, the guide wire 44 is removed 80 from the stimulation lead 30. Then the stimulation lead 30 is anchored 64 and the incision 68 is closed 66 similar to the second minimally invasive method embodiment 74.

A portion of the forth minimally invasive method embodiment 82 can also be used simply for stimulation lead 30 placement for acute test stimulation rather than implantation. For stimulation lead 30 placement, typically the same procedure is used as for implantation through removing 80 the guide wire 44 from the stimulation lead 30. Once the guide wire 44 is removed, stimulation lead 30 placement is validated to ensure the stimulation lead 30 is in the desired location 35.

Thus, embodiments of a minimally invasive sacral lead implantation method 48 are disclosed with many benefits. Embodiments of the method can reduce patient surgical complications, reduce patient recovery time, and reduce healthcare costs. One skilled in the art will appreciate that the present invention can be practiced with embodiments other than those

disclosed. The disclosed embodiments are presented for purposes of illustration and not limitation, and the present invention is limited only by the claims that follow.